STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 01 B. WING	09/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/05/12 Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Avalon Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The facility has a capacity of 67 and had a census of 45 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage. The bathrooms in resident rooms 308 and 310 were not sprinklered. All other areas providing customary access to the residents were sprinklered. The only unsprinklered area providing facility services was the generator room. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/10/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 14 resident room corridor doors on the 300 hall closed and latched into the door frame. This deficient practice could affect 21 residents on the 300 hall. Findings include: Based on observation with the Executive Director on 09/05/12 at 11:25 a.m., the corridor door to resident room 301 failed to latch into the door frame. This was acknowledged by the Executive Director at the time of observation.	K0018	K0181. The resident that occupied room 301 was not affected related to the door not latching properly. The resident room door was adjusted immediately.2. All other residents had the potential to be affected. All other resident room doors were inspected to ensure compliance with state law.3. The Maintenance Director was educated by the Executive Director on 9/6/12 that state law requires all resident room doors to latch into the door frame.4. The ED/designee will monitor that all resident room doors latch into the door frame daily x 4 weeks, then weekly x 4 weeks and monthly thereafter for at least 6 months. The results will be forwarded to the CQI committee.5. Completion Date: 9/21/12	09/21/2012

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	3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided in the bathrooms for 2 of 34 resident rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect 21 resident in the 300 hall in the event of an emergency. Findings include: Based on observations with the Executive Director and the Maintenance Supervisor on 09/05/12 from 11:50 a.m. to	K0056	1. The residents that occupy rooms 308 and 310 were not affected. Rooms 308 and 310 have been sprinkled per state law requirements.2. All other resident rooms were inspected and found to be sprinkled.3. The Maintenance Director was educated by the ED on 9/6/12 in regards to state law of sprinkler coverage.4. The ED/designee will ensure compliance with NFPA, standard for the installation of sprinkler systems, and will perform rounds weekly to ensure proper condition and compliance x 4 weeks, then monthly for at least 6 months. The results of this monitoring will be forwarded to the CQI committee.5. Completion Date: 9/21/12.	09/21/2012

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	11:52 a.m., the bathrooms in resident rooms 308 and 310 lacked sprinkler coverage. Based on an interview with the Executive Director and the Maintenance Supervisor at the time of observations, a large room was converted into two resident rooms with bathrooms within the last year. 3.1-19(b) 3.1-19(ff)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator be provided in a location readily observable by operating personal at a regular work station. LSC 4.6.12.1 requires any device or equipment required for compliance with this Code shall thereafter be continuously maintained. LSC 9.6.1.7 says, to ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with NFPA 72, National Fire Alarm Code. NFPA 72, 7-4.3 requires all apparatus requiring resetting to maintain normal operations shall be reset as promptly as possible after each test and alarm. This deficient practice could affect all occupants.	K0144	1. There were no residents that were affected by this practice.2. All residents had the potential to be affected. The generator switch was placed back into automatic mode.3. The Maintenance Director was educated by the ED on 9/6/12 on resetting the switch promptly after each test and alarm to maintain normal operations.4. The ED/designee will monitor the annunciator panel daily x 4 weeks and monthly therafter for at least 6 months to ensure compliance. The results will be forwarded to the CQI committee. 5. Completion Date: 9/22/121. There were no residents affected by this practice. 2. All residents had the potential to be affected. The generator transfer time has been adjusted to meet requirements of 10 seconds or less.3. The Maintenance Director was educated by the ED on 9/6/12 on the requirements of NFPA, the generator shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. 4. The ED/designee will monitor weekly x 4 weeks that the transfer time is	09/21/2012

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	Findings include: Based on observation with the Maintenance Supervisor on 09/05/12 at 1:35 p.m., the red light was flashing on the generator annunciator panel indicating the "Generator Switch Off." The generator annunciator panel was located at the main nurses' station. Based on an interview with the Maintenance Supervisor at the time of observation, he stated the switch needed to be returned to the automatic mode. Once the system was returned to automatic mode, the indicator light quit flashing. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage		10 seconds or less, then monthly for at least 6 months. The results of this monitoring will be forwarded to the CQI committee. 5. Completion Date: 9/21/12.	

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	stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants Findings include: Based on review of the "Weekly Exercise/Monthly Load Test Log" with the Maintenance Supervisor on 09/05/12 at 12:50 p.m., the monthly load test record indicated the transfer of power from the main source to the emergency generator took between fourteen and fifteen seconds for the months of January through August 2012. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)			